Sapphire Physical Therapy Financial Policy

By executing this agreement, you are agreeing to pay for all services that are received.

Please select the option(s) you prefer:

Payment options if you DO NOT have insurance:

1. ☐ You choose to pay by cash, check, or credit card at the time the services are rendered. Our cash payment option for patients without insurance is $155 per visit. Payment is expected at time of service. If extenuating circumstances should arise, you can discuss a payment plan with our Practice Manager, Jennifer Blank.

Payment options if you DO HAVE insurance:

1. ☐ If you still have a ***deductible to meet*** , you choose to pay $200 per visit by cash, check, or credit card at the time services are rendered. We will send your claim to your insurance carrier and will bill you for additional patient responsibilities, if any, which will be determined by your carrier.

2. ☐ You choose to pay your ***co-payment and/or coinsurance*** , determined by your insurance carrier, by cash, check, or credit card at the time services are rendered. If there is a balance on your account at the end of the month we will bill you accordingly. Any balances without a payment within 30 days of the date of service will be charged a recurring $6 monthly re-billing/finance charge until services are paid in full.

☐ I will make payments at time of service
☐ I will make a payment arrangement for my account
☐ **Work Related** (My workers compensation carrier authorized physical therapy)
☐ **Motor Vehicle** (A motor vehicle insurance company authorized physical therapy)

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance/rebilling charge, if any, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by either John Fiore, Owner or Jennifer Blank, Practice Manager, the balance of your statement is due and payable when the statement is issued and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid in full at the time of service.

Finance Charge: A finance charge will be imposed on your account when it has not been paid within (30) days of the statement date. The finance charge will be $1 per billing period and will accrue every (30) days when a payment has not been made on your account.

Re-billing Fee: A re-billing fee of $5 will be imposed on each account that is over (30) days past due and a payment has not been made, unless other payment arrangements and a payment plan have been agreed upon.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. We reserve the right to refer your account to an attorney or collection agency. You agree to pay all attorney fees and collection costs incurred in enforcing the terms of this agreement.

Returned Checks: There is a $25 fee for any checks returned by your bank.

Workers Compensation: We require written approval/authorization by your worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for your payment in full.

Motor Vehicle Accidents: If the insurance policy involved in any motor vehicle accident claim does not accept liability for your claim, you will be held responsible for your payments in full.

No Show/Cancelled Appointments: We reserve the right to charge a $50 fee for a third consecutive no show/cancelled appointment. The fee must be paid before a new appointment is scheduled. We also may ask you to switch to same day only scheduling. We require a 24 notice for all cancellations.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name:_____ Date:_____

Responsible Party: _____

(if not the patient)

Signature: _____

SAPPHIRE
PHYSICAL THERAPY

Patient Information

Name:
First Middle Last

Date of Birth: Height: Weight: Sex: M F Gender Identity:

Street Address:

City: State: Zip:

Email:

☐ Check to receive monthly clinic newsletter

Phone: (home) (mobile) (work)

Would you like us to provide appointment reminders by? Voicemail ☐ Email ☐

Employer:

Referring Physician:

Primary Physician: Date of last Physician Exam:

How did you hear of us?

Emergency Contact

Contact Name: Relationship:

Phone: (home) (mobile) (work)

Consent to Treatment

*I authorize Sapphire Physical Therapy to treat me/my child. I understand methods of treatment may include, but are not limited to: Therapeutic Exercises, Manual Therapy and other modalities as deemed appropriate by my Physical Therapist per standard of care.

*I understand that I am responsible for all charges incurred regardless of insurance or third party liability.

*I authorize contact by the use of my mobile/cell phone number for discussing treatment, confirming appointments and resolution of the balance of my account.

*I authorize Sapphire Physical Therapy to release any medical information necessary to process my claim to my insurance company or to any other concerned third party.

*I understand that I will bear the cost for all associated collections and/or attorney/legal fees if my account is placed with a 3rd party agency and/or attorney for collections or legal action.

*I authorize my insurance company or any other concerned third party to make payment directly to Sapphire Physical Therapy.

*For patients under 18 years of age; the parent, relative or person *escorting* the patient is responsible for any payments due at the time of the service.

Signature _____ **Date** _____

IF PATIENT IS UNDER THE AGE OF 18

Mother's Name_____Employer_____

Phone #_____ Father's Name _____

Employer _____ Phone#_____

SAPPHIRE
PHYSICAL THERAPY

History of Present Problem

What is the main reason for your Physical Therapy evaluation today?

When did you first notice the problem?

☐ Days ago ☐ Weeks ago ☐ Months ago ☐ Years ago

Other: _____

Do you have any other symptoms?

No ☐ Yes(Please explain):

How does the problem interfere with daily functions?

No ☐ Yes(Please explain): _____

Have you had any falls this past year? No ☐ If yes, how many? _____

Have you had any diagnostic testing for your present injury/issue? (MRI, Xray, CT,ect.)

Problem **worsens** with: (check all that apply)

☐ Movement	☐ Standing	☐ Morning	Other: _____
☐ Bending	☐ Lying	☐ Evening	
☐ Walking	☐ Sitting	☐ As the day progresses	
☐ Turning	☐ Rest	☐ Interrupts Sleep	

Problem **improves** with: (check all that apply)

☐ Movement	☐ Standing	☐ Rest	☐ Medication
☐ Inactivity	☐ Lying	☐ Heat	☐ Morning Other: _____
☐ Walking	☐ Sitting	☐ Ice	☐ Evening
☐ Turning	☐ Bending	☐ Exercise	☐ As the day progresses

On a scale of 0-10 (0 is no pain, 10 is worst pain imaginable), check the number that best describes:

Your current pain?

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

At worst?

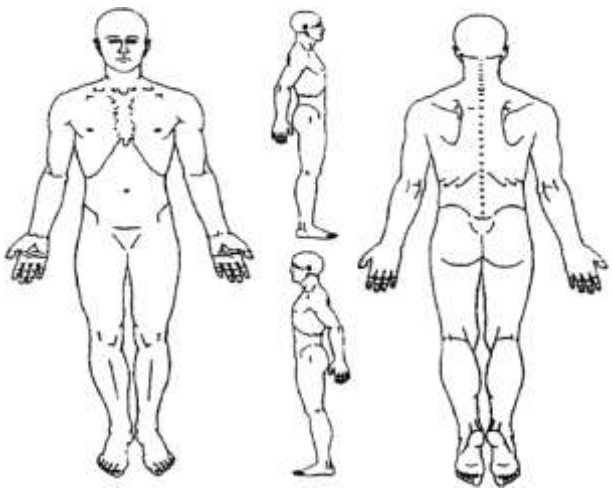
0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

At best?

0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Please mark the location of the pain on the diagram below.

☐ Intermittent



How frequently are you bothered by this problem?

☐ Constant
☐ Intermittent

Other: _____

How would you describe the pain? (Check all that apply)

☐ Dull/Achy	☐ Burning
☐ Sharp	☐ Throbbing
☐ Dull then Sharp	☐ Shooting
☐ Constant	☐ Numbness/Tingling
☐ Worse in morning	☐ Worse at Night

SAPPHIRE
PHYSICAL THERAPY

Personal Medical History: Please check any that apply to ***you*** .

☐ Diabetes(type I or II)	☐ Hernia	☐ Seizures/Epilepsy
☐ Arthritis (RA/OA)	☐ Fibromyalgia	☐ TBI
☐ Tuberculosis	☐ Autoimmune Disorder	☐ Pacemaker
☐ Breast Cancer	☐ Other Cancer	☐ Hepatitis(A,B,C)

Other Chronic, Recurrent or Severe Illness(es):

Review of Systems

Do you now or have you had any problems related to the following systems?
Please check all that apply, if other please explain.

Allergic/Immunologic
- ☐ Hay Fever
- ☐ Drug Allergies
- ☐ Asthma

Other: _____

Ear/Nose/Throat/Mouth
- ☐ Ear Infection
- ☐ Sore Throat
- ☐ Sinus Problems

Other: _____

Respiratory
- ☐ Wheezing
- ☐ Frequent Cough
- ☐ Shortness of Breath
- ☐ Pneumonia

Other: _____

Constitutional Symptoms
- ☐ Fever
- ☐ Chills
- ☐ Headache
- ☐ Night pain

Other: _____

Musculoskeletal
- ☐ Joint Pain
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Muscle Pain

Other: _____

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea/Vomiting
- ☐ Indigestion/Heartburn

Other: _____

Hematologic/Lymphatic
- ☐ Swollen glands
- ☐ Cysts
- ☐ Blood clotting problem

Other: _____

Eyes
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Pain

Other: _____

Endocrine
- ☐ Excessive thirst
- ☐ Too hot/cold
- ☐ Tired/Sluggish

Other: _____

Integumentary
- ☐ Skin Rash
- ☐ Boils
- ☐ Persistent Itch

Other: _____

Genitourinary
- ☐ Kidney Disease
- ☐ Urinary Retention
- ☐ Painful Urination
- ☐ Urinate Frequently
- ☐ Incontinence/Leaking

Other: _____

Neurological
- ☐ Tremors
- ☐ Dizzy Spells
- ☐ Numbness/Tingling

Other: _____

SAPPHIRE
PHYSICAL THERAPY

Cardiovascular

Chest Pain ☐
Stroke ☐
Varicose Veins ☐
Deep Vein Thrombosis ☐
High Blood Pressure ☐
Heart Disease ☐
Pulmonary Embolism ☐
Blood Thinners ☐
Congestive Heart Failure ☐
Other: _____

Psychologic

Are you generally satisfied with your life? Yes ☐ No
Have you considered suicide? Yes ☐ No
Do you suffer from depression? Yes ☐ No

List all health conditions in your ***family.*** (Example: Diabetes, Tuberculosis, Breast Cancer, Heart disease, etc.)

_____

_____

Are you on any prescription medications? No ☐ Yes(Please list all or provide list)

Name Dose Frequency

_____

_____

_____

Any over the counter medications? No ☐ Yes, please explain: _____
Do you have any allergies? No ☐ Yes, please explain: _____
How much caffeine do you consume daily? No ☐ Yes, How much? _____
Do you drink? No ☐ Yes, How much? _____
Do you use nicotine? No ☐ Yes, How much? _____
Cigarettes ☐ E-Cig ☐ Chew ☐ Cigars ☐ Patch ☐

Do you have any other conditions that may limit your response to exercise? No ☐
Yes, please explain: _____
Have you had any recent illnesses within the past 2-3 weeks? (i.e. Colds, flu, bladder/kidney infection.) No ☐
Yes, please explain: _____
Have you noticed any lumps or thickening of skin or muscle anywhere in your body? No ☐
Yes, please explain: _____
Do you have any sores which haven't healed or any changes in size, shape or color of wart or mole? No ☐
Yes, please explain: _____
Do you have any special needs and or considerations? No ☐
Yes, please explain: _____
What are your hobbies/recreational activities? No ☐

_____

What is your goal for therapy at this time? _____

_____

Have you had any unexplained weight loss or gain in the last month? No ☐
Yes, please explain: _____

Is there a possibility that you may be pregnant? Yes ☐ No ☐

SAPPHIRE
PHYSICAL THERAPY

RELEASE OF INFORMATION

Sapphire Physical Therapy
1705 Bow St.
Missoula, MT 59801
(406) 549-5283
(406) 549-5392 fax

Thank you for referring your patient to Sapphire Physical Therapy.

Please forward the medical records regarding this patient so we may provide proper treatment to your patient.

I authorize the release of and correspondence regarding my (or my dependent's) medical records to Sapphire Physical Therapy.

Date _____

Patient Name _____

Date of Birth _____

Signature _____ **Date** _____

SAPPHIRE
PHYSICAL THERAPY

NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information

Uses and Disclosure of Health Information:

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization:

Except as stated in more detail in the Notice of Privacy Practice, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring your Authorization:

In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care
- For certain limited research purposes
- For purpose of health and safety
- To Government agencies for purposes of their audits, investigations, and oversight activities
- To Government authorities to prevent child abuse and domestic violence
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas, and as otherwise required by law

Patient Rights:

As our patient, you have the following rights:

- To have access to and/or copies of your health information
- To receive an account or certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence.
- To request that we amend your health information
- To receive notice of our privacy practices

Please contact us with any questions, concerns, or complaints regarding our privacy practices.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

Patient Name (Please Print)_____

Parent or Authorized Representative (if applicable)_____

Signature **Date**